Authorization for Use and Disclosure of Protected Health Information for reasons <u>other</u> than treatment, payment or healthcare operations

This authorization, if signed, will authorize Duane Reade to use and disclose certain protected health information that is in our possession about the person named below.

This authorization is voluntary and you may refuse to sign this authorization.

1. I hereby authorize Duane Reade to disclose protected health information relating to:
Pharmacy customer's Name: _____
Date of Birth: _____/_____/_____

2. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):
___ Medication(s) [List] from (Date) _____ to (Date) _____
___ Prescription records* and all information on the prescription record from (Doctors' Names)

_____ _____ _____
_____ _____ _____
_____ _____ _____
___ All Prescription records* (All Doctors)
___ Other _____
* We may not give a patient a copy of a prescription for a controlled substance. For copies of other types of prescriptions, we must indicate that the copy is for informational purposes only.

3. This information may be disclosed to and used by the following individual(s) or organization(s):

_____
Address: _____ for the purpose of: _____
Address: _____ for the purpose of: _____
Address: _____ for the purpose of: _____

4. I understand that this information may include information relating to:
- Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.
- Treatment for drug or alcohol abuse.
- Mental or behavioral health or psychiatric care.

5. The persons who are authorized to disclose this information are:
- Personnel in Duane Reade Pharmacy Departments
- Personnel in Duane Reade Compliance/Legal Departments

6. I acknowledge the following statements:

I understand that Duane Reade may not condition treatment on the completion of this authorization. Initials: _____

I understand that I may revoke this authorization at any time by notifying Duane Reade in writing of my intent to revoke this authorization. If I do notify Duane Reade in writing of my intent to revoke this authorization, such revocation will not have any affect on any actions by Duane Reade taken before the revocation. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My notification must be addressed to:

Attn: Privacy Officer Duane Reade
440 Ninth Ave
New York, NY 10001

Unless otherwise revoked, this authorization will expire on the following date, event or condition:
_____.
If no expiration date, event or condition is specified, this authorization will expire in one year.
Initials: _____

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient because it may no longer be protected by federal privacy regulations.
Initials: _____

I understand that I may inspect and copy the information to be disclosed pursuant to this authorization form before I sign this form if I ask to do so.
Initials: _____

I understand that Duane Reade will give me a copy of this authorization form after I sign it.
Initials _____

Printed name of pharmacy customer's representative giving authority to act for pharmacy customer: _____
Signature of pharmacy customer or legal representative: or patient's representative: _____
Date: _____
If signed by legal representative, authority to act for pharmacy customer.
_____
_____
Signature of witness:
_____ Date: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

STATE OF NEW YORK)

SS.:
COUNTY OF NEW YORK)

On the day of , in the year before me, the undersigned, personally appeared _____, personally know to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s) or the person acted upon behalf of which the individual(s) acted, executed the instrument.

_____
Notary Public

Additional Requirements If Patient is Deceased

If you are the administrator or executor of the deceased patient's estate, or if you otherwise have legal authority to act on behalf of the patient or his/her estate, (e.g. you have letters testamentary issued by a court), we can release information to you upon your written request which documents and attests to your legal authority to act on behalf of the deceased patient. We can also release information to you if you obtain and provide us with the written consent from the administrator, executor or legal representative of the deceased patient.

Please complete this form and attach all documents that attest to your legal authority to act on behalf of the deceased patient. Upon Duane Reade's review of the completed "**Authorization for Disclosure of Protected Health Information"** form and attached documentation, a determination to disclose or decline to disclose will be made.

Duane Reade promises to expedite this request and will make every reasonable effort to comply with this request.

Thank you.